The RACs Are Coming -- Are You Ready?

I. INTRODUCTION

The Centers for Medicare and Medicaid Services ("CMS" or "Medicare") Recovery Audit Contractor ("RAC") program has been made permanent and is expanding nationwide, beginning this year. Medicare providers, suppliers and their legal counsel should begin now to prepare for the RACs and increasing Medicare auditing activity. This article will provide an overview of the RAC program and will provide tips for legal counsel representing Medicare providers and suppliers that soon may find themselves subject to RAC audits.

II. RECOVERY AUDIT CONTRACTORS

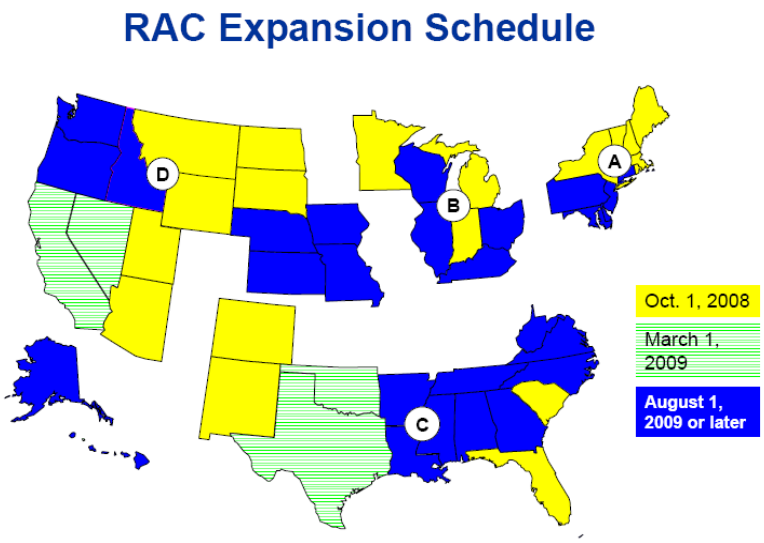
A. The RAC Demonstration Program

Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA"), directed the Department of Health and Human Services ("HHS") to conduct a three-year demonstration program using RACs. The RAC demonstration program began in 2005 in the three states with the highest Medicare expenditures (California, Florida and New York) and in 2007 expanded to include three additional states (Massachusetts, South Carolina and Arizona). The RACs were tasked to identify and correct Medicare overpayments and underpayments, and were compensated on a contingency fee basis based upon the principal amount collected from and/or returned to the providers or suppliers. There were two types of RACs in the demonstration program: claim RACs and Medicare Secondary Payor ("MSP") RACs. The purpose of the demonstration was to determine whether the use of RACs would be a cost-effective way to identify and correct improper Medicare payments.[1]

The RAC demonstration program proved highly "cost effective" from the point of view of CMS. Over the course of the three-year demonstration, the RACs identified and collected more than $1.03 billion in improper payments, and according to CMS, the RAC program was successful in returning $693.6 million to the Medicare Trust Funds. CMS estimates that the RAC demonstration program cost approximately 20 cents for each dollar returned to the Medicare Trust Funds.[2]

B. The RAC Permanent Program

Section 302 of the Tax Relief and Health Care Act of 2006 made the RAC program permanent and required its expansion nationwide by no later than 2010. CMS is actively moving forward with this expansion. Medicare providers and suppliers in numerous states can expect the beginning of RAC auditing activity in the very near future. According to its most-recently published "Expansion Schedule," CMS plans to expand to 19 states by October 1, 2008, four more states by March 1, 2009, and the remaining states by August 1, 2009 or later.[3] It is anticipated that the names of the "permanent RAC" vendors will be announced sometime before October 2008. Medicare providers and suppliers can expect commencement of RAC auditing activity soon after the announcement of the permanent RAC vendors.



RACs are tasked to attempt to identify improper payments resulting from:

- Incorrect payments;
- Non-covered services (including services that are not reasonable and necessary);[4]
- Incorrectly coded services (including DRG miscoding); and
- Duplicate services.[5]

Pursuant to 42 U.S.C. § 1395ddd and the RAC Statement of Work, RACs are prohibited from selecting claims at random to review. Instead, RACs use proprietary "data analysis techniques" to determine claims likely to contain overpayments, a process known as "targeted review."[6] A result of RACs engaging in these "targeted reviews" is that certain types of claims and certain provider types may see more RAC auditing activity than others.[7] For example, during the RAC demonstration program, 85 percent of the alleged overpayments identified and collected arose from inpatient hospital claims; 4 percent arose from outpatient hospital claims; and the remaining 11 percent arose from inpatient rehabilitation facility claims, skilled nursing facility claims, physician claims, durable medical equipment claims, and other types of claims.[8]

In conducting its reviews, RACs are required to comply with all National Coverage Decisions ("NCDs"), Coverage Provisions in Interpretive Manuals, national coverage and coding articles, Local Coverage Decisions ("LCDs"), and local coverage and coding articles in their respective jurisdictions.[9]

C. Differences between the RAC Demonstration and the Permanent Program

During the course of the demonstration program, Medicare providers and suppliers raised significant concerns with certain aspects of the RAC program. CMS has made efforts to address these concerns and adopted numerous changes to be implemented in the permanent program. Some of these changes include the following:

- Under the RAC demonstration program, RACs were permitted to reopen claims up to four years following the date of initial payment. Amid arguments that this four year

look-back period violated the "provider without fault" provisions of the Social Security Act, under the permanent RAC program, RAC reviewers have a maximum three-year look-back period. In all states (regardless of expansion date), the permanent program will begin with a review of claims paid on or after October 1, 2007. However, as time passes, the RACs will be prohibited from reviewing claims more than three years past the date of initial payment. [10]

- Under the RAC demonstration program, the RACs were not required to employ a physician medical director or coding expert. However, under the permanent program, when performing coverage or coding reviews of medical records requested from a Medicare provider or supplier, nurses (RNs) or therapists are required to make determinations regarding medical necessity and certified coders are required to make coding determinations. The RACs are not required to involve physicians in the medical record review process; however, the RACs are required to employ a contractor medical director ("CMD"), who is a doctor of medicine or doctor of osteopathy, and arrange for an alternate CMD in the event that the CMD is unavailable for an extended period. The CMD will provide services such as providing guidance to RAC staff regarding interpretation of Medicare policy.[11]

- CMS compensates RACs on a contingency fee basis, based upon the principal amount of collection (or the amount paid back to) a provider or supplier. Under the demonstration program, the RACs were entitled to keep their contingency fees if a denial was upheld at the first stage of appeal, regardless of whether a provider prevailed at a later stage of the appeals process. Significantly, many providers were successful at later stages of the appeals process. This fee arrangement provided incentive to the RACs to aggressively review and deny claims, contributing to the perception within the Medicare provider and supplier community that the RACs were nothing more than "bounty hunters." For their efforts, the RACs earned $187.2 million in contingency payments over the course of the demonstration (or approximately 14.4 percent of all alleged improper payments identified).[12] In a significant change from the demonstration program, under the permanent RAC program, if a provider files an appeal disputing an overpayment determination and wins this appeal at any level, the RAC is not entitled to keep its contingency fee and must repay CMS the amount it received for the recovery.[13]

III. RAC PLANNING AND COMPLIANCE

As noted above, Medicare providers and suppliers in at least 19 states can soon expect the commencement of RAC auditing activity. Medicare providers and suppliers nationwide are well advised to begin preparing for the RACs and increased Medicare auditing activity now. Medicare providers and suppliers can begin to prepare by dedicating resources to:

- Responding to record requests within the required timeframes;

- Internally monitoring protocols to better identify and monitor areas that may be subject to review;

- Implementing compliance efforts, including, but not limited to, documentation and coding education; and

- Properly working up appeals to challenge denials in the appeals process. With regard to medical necessity and similar denials, this will clearly entail physician involvement.

In conducting reviews of medical records, RACs are authorized to obtain medical records either from onsite reviews, or by requesting that providers or suppliers mail, fax, or otherwise transmit medical records to the RACs for review.[14] RACs are authorized to find an overpayment where medical records are requested but not received within 45 days from the date of request.[15] It is imperative that Medicare providers and suppliers have systems in place to track records requests made by the RACs to ensure that they timely respond to such requests.[16]

Once Medicare providers and suppliers have developed and implemented systems for timely responding to medical records requests made by the RACs, the next step is to adopt and implement and/or update existing compliance activities. Reviewing the types of denials made during the RAC demonstration program is one helpful tool for Medicare providers and suppliers to identify potential target areas for the RACs operating in the permanent program. [17] During the course of the RAC demonstration program:

- 35 percent of the improper payments identified were the result of incorrect coding;

- 40 percent were denied because the claims did not meet Medicare's medical necessity criteria; and

- 8 percent were denied for the reason, "no/insufficient documentation" (meaning the RAC requested the information but the entity did not respond timely or completely).

- 17 percent were denied for "other" reasons, including that claims were paid based upon outdated fee schedules, duplicate claims, etc.[18]

Medicare providers and suppliers are well advised to adopt and implement compliance policies and procedures to address these and other areas of Medicare scrutiny now, before the RACs begin nationwide auditing.

IV. CLAIM DENIALS AND MEDICARE APPEALS

If a Medicare provider or supplier receives a claim denial, or a finding of overpayment is made as a result of a RAC review, this denial will be subject to the uniform Medicare Part A and Part B appeals process. The regulations governing this process are contained at 42 C.F.R. § 405.900 *et seq.* In summary, the Medicare appeals process is as follows:

- The first level in the appeals process is *redetermination*. Providers must submit redetermination requests in writing within 120 calendar days of receiving notice of initial determination. There is no amount in controversy requirement.[19]

- Providers dissatisfied with a Carrier's or Intermediary's redetermination decision may file a request for *reconsideration* to be conducted by a Qualified Independent Contractor ("QIC"). This second level of appeal must be filed within 180 calendar days of receiving notice of the redetermination decision. There also is no amount in controversy requirement for this stage of appeal.[20]

- The third level of appeal is the *Administrative Law Judge ("ALJ") hearing*. A provider dissatisfied with a reconsideration decision may request an ALJ hearing. The request must be filed within 60 days following receipt of the QIC's reconsideration decision.[21] The request must meet an amount in controversy requirement. ALJ hearings can be conducted by video-teleconference ("VTC"), telephone or in person. The regulations require the hearing to be conducted by VTC if the technology is available; however, if VTC is unavailable, or in other circumstances, the ALJ may hold a telephone hearing or an in-person hearing.[22]

- The fourth level of appeal is the *Medicare Appeals Council ("MAC") Review*. The MAC is within the Departmental Appeals Board of the U.S. Department of Health and Human Services. A MAC Review request must be filed within 60 days following receipt of the ALJ's decision and meet an amount in controversy requirement.[23]

- The final step in the appeals process is judicial review in *federal district court*. A request for review in district court must be filed within 60 days of receipt of the MAC's decision and meet an amount in controversy requirement.[24] In a federal district court action, the findings of fact by the Secretary of HHS are deemed conclusive if supported by substantial evidence.[25]

V. STRATEGIES FOR DEFENDING MEDICARE AUDITS

Many strategies exist that can be employed successfully in the appeals process to effectuate meaningful results.[26] These strategies involve effectively advocating the merits of the underlying services as well as employing legal defenses.

A. Advocating the Merits

When advocating the merits of a claim, many attorneys representing Medicare providers and suppliers find it useful to draft a position paper outlining the factual and legal arguments in support of payment for a disputed claim. In many cases it is advantageous to engage the services of a qualified expert, particularly when an audit or claim denial involves issues of medical necessity.

B. Audit Defenses

In addition to advocating the merits of a claim through various techniques, certain legal defenses are available. Defenses that have proven valuable for providers and suppliers challenging Medicare audit determinations include: invoking the treating physician rule, arguing the "Waiver of Liability" defense, arguing the provider is without fault, challenging the

timeliness of the audit and/or claim denial, and challenging the statistical extrapolation (if one was involved).

1. Treating Physician Rule

The treating physician rule involves the legal principle that the treating physician, who has examined the patient and is most familiar with the patient's condition, is in the best position to make medical necessity determinations. The treating physician rule, as adopted by some courts, reflects that the treating physician's determination that a service is medically necessary is binding unless contradicted by substantial evidence, and is entitled to some extra weight, even if contradicted by substantial evidence, because the treating physician is inherently more familiar with the patient's medical condition. As noted above, RACs utilize the services of registered nurses (rather than physician reviewers) to conduct reviews regarding medical necessity. Providers and suppliers should reference the treating physician rule to demonstrate that the treating physician's medical judgment as to the medical necessity of the services provided should be given deference.

2. Waiver of Liability

Pursuant to the Medicare "waiver of liability" defense, providers and suppliers may be entitled to payment for claims a RAC or other Medicare contractor has deemed not reasonable and necessary. Under the waiver of liability provisions of the Social Security Act, even if a service is determined to be not reasonable and necessary, payment nonetheless may be rendered if the provider or supplier did not know, and could not reasonably have been expected to know, payment would not be made.[27] The relevant inquiry focuses on whether the provider or supplier "knew or could have reasonably been expected to know" payment would not be made. Therefore, to demonstrate that a Medicare provider or suppliers did not know and could not reasonably have been expected to know payment would not be made for a claim, providers and suppliers must have access to all relevant Carrier or Intermediary communications with the provider and supplier community and with the particular provider or supplier. Waiver of liability generally only applies to determinations that a service was not medically necessary.

3. Provider without Fault

Additionally, the "provider without fault" defense may be employed in the case of post-payment review denials. The Medicare provider without fault provisions are codified at Section 1870 of the Social Security Act, and state that payment will be made to a provider or supplier if the provider or supplier was without "fault" with regard to billing for and accepting payment for disputed services.[28] As a general rule, a provider or supplier will be considered without fault if it exercised reasonable care in billing for and accepting payment, i.e., complied with all pertinent regulations, made full disclosure of all material facts, and on the basis of the information available, had a reasonable basis for assuming the payment was correct.[29]

In addition, providers and suppliers will be deemed to be without fault in the absence of evidence to the contrary, if an overpayment was discovered subsequent to the third calendar year after the year of payment.[30] As noted herein, under the RAC demonstration program, RACs were permitted to reopen claims up to four years following the date of initial payment.[31] Many providers and suppliers were successful arguing that this four year look-back period violated the "provider without fault" provisions of the Social Security Act, and were successful in overturning untimely overpayment determinations.

4. Reopening Regulations

Medicare regulations recognize that, in the interest of equity, Medicare providers and suppliers must be able to rely on coverage determinations. Thus, Medicare regulations place restrictions upon the permissible timeframe for reopening initial determinations. Pursuant to 42 C.F.R. § 405.980 (b), a contractor may reopen and revise its initial determination:

1. Within 1 year from the date of the initial determination for any reason;

2. Within 4 years of the date of the initial determination for good cause as defined in 405.986.

3. At any time if there exists reliable evidence as defined in Sec. 405.902 that the initial determination was procured by fraud or similar fault as defined in Sec. 405.902.

4. At any time if the initial determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based.

Pursuant to 42 C.F.R. § 405.986, "good cause" may be established when:

1. There is new and material evidence that—

    i. Was not available or known at the time of the determination or decision; and

    ii. May result in a different conclusion; or

2. The evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision.[32]

Further, according to the Medicare Financial Management Manual, "If an overpayment is determined based on a reopening outside of the above parameters, the FI or carrier will not recover the overpayment."[33]

Although providers and suppliers have experienced success challenging reopenings under these regulations during the RAC demonstration, providers and suppliers should be aware that a recent Medicare Appeals Council decision has found CMS to lack jurisdiction to consider challenges to reopenings under the Medicare appeals process.[34] Nonetheless, an argument exists that even if a provider or supplier may not challenge the Medicare contractor's authority to reopen a claim, they may still be able to challenge the Carrier's or Intermediary's decision to "revise" that claim following the reopening.

5. Challenges to Statistics

In many post-payment audits, CMS will audit a small sample of a provider's or supplier's records, and if it finds an overpayment, CMS will extrapolate the overpayment to the provider's or supplier's entire patient population. The MMA sets limits regarding when statistical extrapolation may be used, and the Medicare manuals establish guidelines for CMS to follow when performing an audit based upon a statistical sample.[35] If an extrapolation is flawed, it may be successfully challenged, bringing the total dollars at issue to the "actual" alleged overpayment, and not the extrapolated alleged overpayment. In order to best challenge a statistical sample and extrapolation, many providers and suppliers have found it useful to engage the services of a qualified statistician expert witness, to testify regarding the sample chosen and statistical extrapolation performed. For example, in one recent case, CMS conducted an audit in which it found an "actual" overpayment of approximately $28,000, which it then extrapolated to determine its overpayment demand of over $1.5 million. With the use of a qualified statistician expert witness, the provider was successful in challenging the methodology of the statistical extrapolation, and the extrapolation was overturned.

VI. CONCLUSION

Medicare providers and suppliers should get ready for increased Medicare auditing activity as the RAC program expands nationwide. Providers and suppliers must act now to evaluate their compliance with Medicare policies. Should a provider or supplier be subject to a RAC or other Medicare audit, effective strategies are available that can be successfully employed in the appeals process to defend Medicare audits.

---

[1] "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 1, June 2008, *available at* http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[2] *Id.*, at p. 15.

[3] RAC Expansion Schedule, *available at* http://www.cms.hhs.gov/RAC/Downloads/RAC%20Expansion%20Schedule%20Web.pdf

[4] Many providers who have experienced traditional Carrier or Intermediary audits have seen that typical bases for denials of claims include denials based upon the medical necessity of the services provided or lack of documentation.

[5] *See generally,* "Statement of Work for the Recovery Audit Contractors Participating in the Demonstration" and "Statement of Work for the Recovery Audit Contractor Program," *available at* https://www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[6] *Id.*

[7] *See generally,* "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 19 and at Appendix F through Appendix I , June 2008, *available at* http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[8] *Id.*

[9] *Id.* As will be discussed in greater detail later in this article, Medicare providers and suppliers subject to RAC audits during the demonstration complained that the RACs failed to abide by Medicare policies in conducting claim reviews in multiple situations.

[10] *See* "Statement of Work for the Recovery Audit Contractors Participating in the Demonstration" at p. 6, and "Statement of Work for the Recovery Audit Contractor Program" at pp.7-8, *available at* https://www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[11] *See* "Statement of Work for the Recovery Audit Contractors Participating in the Demonstration" and "Statement of Work for the Recovery Audit Contractor Program" at p. 19, *available at* https://www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[12] "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 3, June 2008, *available at* http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[13] *See* "Statement of Work for the Recovery Audit Contractors Participating in the Demonstration" at p. 13, and "Statement of Work for the Recovery Audit Contractor Program" at pp.42-43, *available at* https://www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[14] *See* "Statement of Work for the Recovery Audit Contractor Program" at p. 11, *available at* https://www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[15] *Id.* at p. 13.

[16] Many providers and suppliers in the RAC demonstration program found it challenging to address the new administrative challenges posed by the RACs (for example, monitoring and timely responding to volumes of records requests made by the RACs). Some providers and suppliers found it necessary to hire additional administrative personnel, as they struggled to meet the administrative demands of the RACs and at the same time ensure that adequate resources were dedicated to patient care. The RAC Statement of Work for the permanent program acknowledges this challenge, and states that, "[w]hen requesting medical records the RAC shall use discretion to ensure the number of medical records in the request is not negatively impacting the provider's ability to provide care." *See* "Statement of Work for the Recovery Audit Contractor Program" at p. 11, *available at* https://www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[17] "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 19, June 2008, *available at* http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

Over the course of the three-year demonstration, the top services with overpayments included the following:

Type of Provider	Description of Item or Service	Amount Collected Less Cases Overturned on Appeal (Million Dollars)	Number of Claims with Overpayments Less Cases Overturned on Appeal	Location of Problem
Inpatient Hospital	Surgical procedures in wrong setting (medically unnecessary)	88.0	5,421	NY
	Excisional debridement (incorrectly coded)	66.8	6,092	NY, FL, CA
	Cardiac defibrillator implant in wrong setting (medically unnecessary)	64.7	2,216	FL
	Treatment for heart failure and shock in wrong setting (medically unnecessary)	33.1	6,144	NY, FL, CA
	Respiratory system diagnoses with ventilator support (incorrectly coded)	31.6	2,102	NY, FL, CA
Inpatient Rehabilitation Facility	Services following joint replacement surgery (medically unnecessary)	37.0	3,253	CA
	Services for miscellaneous conditions (medically unnecessary)	17.4	1,235	CA
Outpatient Hospital	Neulasta (medically unnecessary)	6.5	558	NY, FL
	Speech-language pathology services (medically unnecessary)	3.2	24,991	NY, CA
	Infusion services (medically unnecessary)	2.3	19,271	CA
Skilled Nursing Facility	Physical therapy and occupational therapy (medically unnecessary)	6.8	77,911	CA
	Speech-language pathology services (medically unnecessary)	1.6	3,012	CA
Physician	Pharmaceutical injectables (incorrect coding)	5.8	18,390	NY, CA
	Neulasta (medically unnecessary)	3.0	56	NY
	Vestibular function testing (other error type)	1.4	13,805	FL
	Duplicate claims (other error type)	1.0	11,165	CA
Lab/Ambulance/Other	Ambulance services during a hospital inpatient stay (other error type)	2.9	13,589	FL, CA
Durable Medical Equipment	Items during a hospital inpatient stay or SNF stay (other error type)	4.8	38.257	NY, FL, CA

See "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at Appendix G p. 38, June 2008, *available at* http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[18] "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at pp. 1 and 19, June 2008, *available at* http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

[19] 42 C.F.R. § 405.942 (2007).

[20] 42 C.F.R. § 405.960-962 (2007).

[21] In addition, if the QIC fails to render its reconsideration decision within the required timeframe, a provider may request an ALJ hearing. 42 C.F.R. § 405.970 (2007).

[22] 42 C.F.R. § 405.1000 *et seq.* (2007).

[23] In addition, if the ALJ fails to render its decision within the required timeframe, a provider may request MAC review of the claim. 42 C.F.R. § 405.1104 (2007).

[24] In addition, if the MAC fails to render its decision within the required timeframe, a provider may request federal district court review of the claim. 42 C.F.R. § 405.1132 (2007).

[25] 42 C.F.R. § 405.1132 *et seq.* (2007).

[26] Based upon information it had available at the time of publication of its evaluation of the RAC demonstration, CMS found that providers had chosen to appeal only 14 percent of RAC determinations. Of these, only 4.6 percent were overturned on appeal. *See* "The Medicare Recovery Audit Contractor (RAC) Program: An Evaluation of the 3-Year Demonstration," at p. 2 and Appendix L at p. 44, June 2008, *available at* http://www.cms.hhs.gov/RAC/Downloads/RAC_Demonstration_Evaluation_Report.pdf.

However, these appeals statistics are premature and potentially misleading to providers and suppliers. The vast majority of the RAC denials were made in the final three months of the program (January through March 2008.) *Id.* at Appendix C p. 33. Thus, at the time CMS published its evaluation, many of these claims had not yet been appealed, but the timeframe to submit redetermination requests had not yet elapsed. Moreover, many of the claims that had been appealed remain in various stages of the appeals process, and may still be overturned.

[27] 42 U.S.C. § 1395pp. *See also* Medicare Claims Processing Manual (CMS-Pub. 100-04), Chapter 30, § 20.

[28] 42 U.S.C.§ 1395gg.

[29] Medicare Financial Management Manual (CMS Pub. 100-06), Chapter 3, § 70.3.

[30] Medicare Financial Management Manual (CMS-Pub. 100-06), Chapter 3, §§ 80 and 90.

[31] *See* "Statement of Work for the Recovery Audit Contractors Participating in the Demonstration" at p. 6, *available at* https://www.fbo.gov/index?s=opportunity&mode=form&id=1889cc7b8672a9e2c1cbe5a007b9dceb&tab=core&_cview=1.

[32] *See also* Medicare Claims Processing Manual (CMS-Pub. 100-04), Chapter 29, § 90 and Medicare Financial Management Manual (CMS-Pub. 100-06), Chapter 3, § 80.1

[33] Medicare Financial Management Manual (CMS-Pub. 100-06), Chapter 3, § 80.1.

[34] *Critical Care of North Jacksonville v. First Coast Service Options, Inc.*, decided February 29, 2008.

[35] Pursuant to Section 935 of the MMA:

> (1) LIMITATION ON USE OF EXTRAPOLATION. –A Medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise, unless the Secretary determines that –
>
> (A) there is a sustained or high level of payment error; or
>
> (B) documented educational intervention has failed to correct the payment error.

Section 1893(f)(3) of the Social Security Act, 42 U.S.C. §1395ddd (emphasis added).

CMS also has established guidelines for statistical extrapolations, which are set forth in the Medicare Program Integrity Manual (CMS Pub. 100-08, Chapter 3, §§ 3.10.1 through 3.10.11.2). Notably, the RACs are

authorized to use extrapolation, provided that they adhere to the above-referenced statute and Manual provisions. *See* RAC Statement of Work, *available at* http://www.cms.hhs.gov/RAC/10_ExpansionStrategy.asp#TopOfPage.

CMS and its contractors must follow these guidelines in conducting statistical extrapolations. If it fails to do so, a Medicare provider may have success challenging the validity of the extrapolation.